Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
P O BOX 24809
HOUSTON TX 77029

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-0900-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the AMA/CPT manual, the code 99214 is described as follows: Office or other outpatient visit for the evaluation & management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Physicians typically spend 25 minutes face to face with the patient and/or family." "Our doctors usually spend 25-30 minutes conducting a re-evaluation of established patients. As noted in the typed subsequent report that was submitted with the HCFA billing, you can clearly note that a comprehensive history is documented under Present Medical Condition on our follow-up exam form. A comprehensive examination including neuro & ortho exams were also performed and documented in the exam form. Decision making of moderate complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations."

Amount in Dispute: $171.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99214 for evaluation and management (E&M) services provided on 12/21/09. Texas Mutual denied payment after reviewing documentation of previous E&M episodes from the requestor billed with code 99213." "The documentation for the 12/21/209 date is substantially and formally very similar to the 99213 codes billed on 5/18/09, 6/25/09, 7/16/09, and 9/10/09. (Exhibit 1) Texas Mutual argues the documentation of the 12/21/09 E&M service is more consistent with 99213. As such, no payment is due." "The requestor billed code 99080-73. The requestor's documentation…also reflects no substantial change in the claimant's status from the DWC-73 submitted by the requestor on 6/18/09. (Exhibit 2)"

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 21, 2009	99214-25	$156.00	$0.00

December 21, 2009	99080-73	$15.00	$15.00
TOTAL		$171.00	$15.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guideline s for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. 28 Texas Administrative Code §129.5 outlines the policies for billing work status reports.
4. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 3, 2010
   - 225 – DOCUMENTATION DOES NOT SUPPORT THE NATURE OF PRESENTING PROBLEMS AS MODERATE TO HIGH SEVERITY PER CPT DESCRIPTION OF 99214. MODIFIER 25 NOT SUPPORTED BY DOCUMENTATION.
   - CAC-W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - CAC-150 — PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - CAC-16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE).
   - 225 — THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 248 — DWC-73 NOT PROPERLY COMPLETED OR SUBMITTED IN EXCESS OF THE FILING REQUIREMENTS; REIMBURSEMENT DENIED PER RULE 129.5.
   - 890 — THIS LEVEL OF SERVICE IS BEING DISPUTED AS IT DOES NOT MEET THE COMPONENTS AS DEFINED IN THE 'CPT BOOK'.

Issues

1. Did the requestor support billing CPT code 99214-25? Is the requestor entitled to reimbursement?
2. Did the requestor support billing CPT code 99080-73? Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for CPT code 99214-25 based upon EOB denial codes: CAC-150 — PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE; CAC-16 — CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE); 225 — THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION; and 890 — THIS LEVEL OF SERVICE IS BEING DISPUTED AS IT DOES NOT MEET THE COMPONENTS AS DEFINED IN THE 'CPT BOOK'.

   CPT code 99214 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family."

   The requestor added modifier "-25" to CPT code 99214. Modifier "-25" is defined as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or

Other Service." A review of the documentation finds that the requestor billed for an office visit and report on the disputed date of service. The documentation does not support the necessity of modifier 25.

The Division finds that the requestor's documentation does not meet the requirements for billing the office visit coded 99214. Therefore, reimbursement is not recommended.

2. The respondent denied reimbursement for CPT code 99080-73 based upon EOB denial codes: CAC-W1 — WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; and 248 — DWC-73 NOT PROPERLY COMPLETED OR SUBMITTED IN EXCESS OF THE FILING REQUIREMENTS; REIMBURSEMENT DENIED PER RULE 129.5.

   CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

   28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

   28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

   28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:

   (1) after the initial examination of the employee, regardless of the employee's work status;

   (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

   The respondent submitted a copy of the work status report that was filed on June 18, 2009. A comparison of this report to the December 21, 2009 report finds changes in posture restrictions, motion restrictions and the maximum hours per day of work; therefore, the requestor has supported filing and billing for the work status report. As a result, the amount recommended for reimbursement is $15.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does support the reimbursement amount sought by the requestor for the report. The Division concludes that the requestor supported its position that reimbursement is due for the work status report. As a result, the amount ordered is $15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/30/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.